

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>DEACONESS HOSPITAL INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 MARY ST EVANSVILLE, IN 47747</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 01-17-13</p> <p>Facility number: 005074</p> <p>Complaint number: IN00116620 Substantiated, No deficiencies related to allegation cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Deaconess Hospital is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: cloughlin 08/23/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE